120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • TEL (877) 624-2249 (781) 828-7000 • FAX (781) 770-0490 • CLIENTSERVICES@BOSTONMUTUAL.COM

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

CLIENT SERVICES DEPARTMENT

Name: _____

Address: _____

_____

_____

Dear Policyholder:

Please complete the appropriate section and mail or fax the completed form to the address or fax number noted above. If you have any questions, please call our Client Services Department at (877) 624-2249.

As owner of the policy(ies) noted below, I authorize you to make the following changes as indicated:

POLICY #: _____ **INSURED:** _____

POLICY #: _____ **INSURED:** _____

❑ **NAME CHANGE:** ❑ Insured ❑ Payor ❑ Beneficiary ❑ Owner
(Do not use this form to designate a new beneficiary or owner.)

FORMER NAME: _____ NEW NAME: _____

Reason for Change: _____

(Please Note: If other than for a spelling error or for Marriage or Divorce - you must provide proof of the change.)

❑ **ADDRESS CHANGE:** ❑ Insured ❑ Payor ❑ Beneficiary ❑ Owner ❑ Employer *(List Bill)*

NEW ADDRESS: _____

_____

❑ **SOCIAL SECURITY NUMBER (SSN) CORRECTION:**
(For policyowner only; Social Security Number for individuals, Corporate Tax I.D. Number for companies.)

OWNER'S NAME: _____ CORRECTED SSN: _____

Reason for Change: _____ ***(Requires Proof of the Corrected SSN)***

❑ **LOST POLICY CERTIFICATE REQUEST**

❑ **DUPLICATE POLICY REQUEST (THERE IS A $10.00 CHARGE FOR A DUPLICATE POLICY WHICH MUST ACCOMPANY YOUR REQUEST)**

- ❑ I have made a persistent search for this policy, but have no knowledge of its whereabouts.
- ❑ My policy is unobtainable at this time, but I agree to send it to Boston Mutual if and when it is located.

Please complete this section with all appropriate signatures and information. Missing data may delay processing.

_____
DATE

_____
OWNER NAME (PLEASE PRINT)

_____
AGENT OR WITNESS SIGNATURE

_____
OWNER SIGNATURE

( ) –
TELEPHONE NUMBER

XXX / XX /
OWNER SOCIAL SECURITY NUMBER *(last 4 digits)*

_____
ADDRESS